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ABSTRACT

The effects of childhood physical and sexual abuse on the development of alcoholism in women was examined by comparing 127 alcoholic women in treatment with two comparison groups. One comparison group was comprised of 83 nonalcoholic women in mental health treatment or receiving services for battering. The second comparison group consisted of 92 nonalcoholic women selected randomly from households in the general population. Face-to-face interviews were administered to all three samples. The Conflict Tactics Scale assessed both father-to-daughter and mother-to-daughter violence. Childhood sexual abuse was defined as sexual contact before age 18 with someone at least 5 years older and/or sexual contact involving a relative. Alcoholic women were significantly more likely to have experienced father-to-daughter physical violence and verbal aggression than either nonalcoholics in treatment or in the general population. Alcoholic women were more likely to have experienced mother-to-daughter physical violence and verbal aggression as compared to the general population but not as compared to the nonalcoholic treatment group. Alcoholic women were also more likely than either of the comparison groups to have experienced each of three forms of childhood sexual abuse: exposure/invitation, touching/fondling, and intercourse. Finally, alcoholic women were more likely than the general population to have experienced both physical and sexual abuse. Women's descriptive accounts suggest that victimization experiences lead to negative feelings about themselves and their lives, including lack of control, setting the stage for substance abuse as a coping strategy. (Author)

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RELATIONSHIP BETWEEN WOMEN'S ALCOHOL PROBLEMS AND EXPERIENCES OF CHILDHOOD VIOLENCE

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ABSTRACT

The effects of childhood physical and sexual abuse on the development of alcoholism in women was examined by comparing 127 alcoholic women in treatment with two comparison groups. One comparison group was comprised of 83 nonalcoholic women in mental health treatment or receiving services for battering. The second comparison group consisted of 92 nonalcoholic women selected randomly from households in the general population. Face-to-face interviews were administered to all three samples. The Conflict Tactics Scale, assessed both father-to-daughter and mother-to-daughter violence. Childhood sexual abuse was defined as sexual contact before 18 with someone at least five years older and/or sexual contact involving a relative. Alcoholic women were significantly more likely to have experienced father-to-daughter physical violence and verbal aggression than either nonalcoholics in treatment or the general population. Alcoholic women were more likely to have experienced mother-to-daughter physical violence and verbal aggression as compared to the general population but not as compared to the nonalcoholic treatment group. Alcoholic women were also more likely than either of the comparison groups to have experienced each of three forms of childhood sexual abuse: exposure/invitation, touching/fondling, and intercourse. Finally, alcoholic women were more likely than the general population to have experienced both physical and sexual abuse. Women's descriptive accounts suggest that victimization experiences lead to negative feelings about themselves and their lives, including lack of control, setting the stage for substance abuse as a coping strategy.

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LINKS BETWEEN CHILD ABUSE AND DEVELOPMENT OF WOMEN'S ALCOHOL PROBLEMS

There has been an increasing interest in the long-term effects of parental violence on the victim, including the development of alcoholism and drug abuse.[1] Childhood physical abuse has been found to be associated with later substance abuse among youth (Dembo et al., 1987; Geller and Ford-Somma, 1984). In addition, Covington (1983) found that alcoholic women were more likely to report both physical and emotional abuse during childhood than nonalcoholic women. Cohen and Densen-Gerber (1982) found that 84% of the females in treatment for drug/alcohol addiction reported a history of childhood abuse.

Our own preliminary work suggests that alcoholic women were significantly more likely to have experienced father-to-daughter negative verbal interaction, moderate violence, and severe violence compared to a random sample of women (Downs, Miller, & Gondoli, 1987). For example, alcoholic women experienced threats against their lives (22%), having been beaten up (23%), and having been hit by an object (46%) at significantly greater rates than the random sample (7%, 5%, and 14%, respectively). Further, when demographic and parental alcoholism were controlled, father-to-daughter violence still significantly contributed to the regression equation for discriminating between alcoholic and the random samples (Downs et al., 1987).

The theoretical explanations for why childhood experiences of parental violence may lead to the development of alcohol or substance problems have not been well developed. We do know that experiences of parental violence may lead to negative emotions toward self (Oates, Forrest, & Peacock, 1985) and set the stage for substance use as a mechanism for relieving these negative feelings and emotions. Drinking for relief of unpleasant feelings has been associated with problem drinking (Fillmore, 1974, 1975).

In exploring these relationships, distinctions need to be made between mother and father violence. For example, Straus, Gelles and Steinmetz (1980) found that mothers were more likely to use serious or abusive violence on children than were fathers. However, given that mothers traditionally have greater child care responsibility than fathers, mothers have more opportunities to use violence on children (Straus et al., 1980). Further substantiating this finding, when time at risk was controlled, fathers were more violent toward children than mothers (Finkelhor, 1983). In another study, the rates of mother-to-child serious violence were higher, while the potentially lethal forms of violence (e.g., using a knife or gun on the child) were more likely to be engaged in by fathers (Straus et al., 1980). Several other studies have suggested that fathers were more likely to physically abuse children while mothers were more likely to neglect their children (cf. Pagelow, 1984).

These differences between father and mother patterns of violence towards their children suggest that one parent may be more important than the other in understanding the links between experiences of child abuse and the development of alcoholism problems in women. Our previous research has found this to be the case. Women alcoholics, as compared to a random sample, were more likely to have experienced father-to-daughter violence but not mother-to-daughter violence (Downs, Miller, & Gondoli, 1987).

LINKS BETWEEN CHILDHOOD SEXUAL ABUSE AND DEVELOPMENT OF WOMEN'S ALCOHOL PROBLEMS

Experiences of childhood sexual abuse may also contribute to the development of alcoholism in women. Reviewing a number of studies on initial and long-term consequences of sexual abuse, Browne and Finkelhor (1986)

reported a wide range of undesirable effects from experiences of childhood sexual abuse. One long-term consequence was the development of alcohol and drug problems by women who previously had been sexually abused (Browne and Finkelhor, 1986). The link between childhood sexual abuse and alcoholism has also been suggested by evidence of childhood sexual abuse incidents for women identified in alcohol or drug treatment. For example, 75% of the adult women admitted to an inpatient chemical dependency rehabilitation program in Maine during January-March of 1986 reported childhood sexual abuse histories (Rohsenow, Corbett, & Devine, 1986). For the same time period, 70% of the adolescent females admitted to the program reported childhood sexual abuse histories.

Studies have also examined the link between childhood sexual abuse and alcoholism by examining the number of women with childhood sexual abuse experiences who reported alcohol and/or drug problems at some point in their lives. Dembo et al. (1989) found that sexual victimization predicted later illicit drug use. Briere (1988) found that clinic outpatients with a history of sexual abuse were more likely to report alcoholism than outpatients without a sexual abuse history. In a study of incest cases, Herman (1981) reports that 20% of the women became alcoholic or drug-dependent at some point in their lives. Given that women have an estimated lifetime prevalence rate for a diagnosis of alcohol dependence or drug dependence around 5% for each (Robins et al., 1984), childhood sexual abuse histories appear to increase the probability of alcohol and/or drug problems.

Conflicting findings regarding alcohol/drug problems have appeared in studies on psychiatric patients with childhood sexual abuse histories. Singer, Petchers, and Hussey (1989) reported higher levels of alcohol and drug

use, as well as more frequent drunkenness, for sexually abused as compared to nonsexually abused psychiatric patients. However, Goldston, Turnquist and Knutson, (1989) found no differences in alcohol and drug abuse for girls in psychiatric care with and without childhood sexual abuse histories.

The importance of childhood sexual abuse incidents as antecedents to alcohol-related problems for women is given further credence by findings from our recent research (Miller, Downs, Gondoli, & Keil, 1987). In comparison to a random sample of women, alcoholic women were significantly more likely to have experienced childhood sexual abuse (67% vs. 28% in random sample). In a discriminant function analysis, childhood sexual abuse predicted alcoholism in adulthood, controlling for the presence of parental alcohol-related problems. Further, although many of our alcoholic women had parents with alcohol-related problems, these parents were not likely to be perpetrators of sexual abuse in either sample. Instead, other adult perpetrators sexually victimized the daughter of parents with alcohol-related problems.

The literature on alcoholism problems of women has not adequately addressed the mechanisms which may link childhood sexual abuse to the development of alcohol problems in women. While this connection is not clear, there are some indications that antecedents to alcoholism are similar to consequences of childhood sexual abuse. In her longitudinal study of alcoholic women, Jones (1971) reported that social isolation and emotional disturbances were more characteristic of adolescents who later developed alcohol problems as compared to adolescents who did not. Likewise, there were indications that emotional disturbances and social isolation were consequences to the sexual abuse experiences (Browne and Finkelhor, 1986).

Experiences of sexual abuse may also lead to distorted self-image and lowered self-esteem, including negative sexual self-labeling, either as a short-term or a long-term effect of childhood sexual abuse. Dembo et al. (1989) found that physical and sexual abuse in juvenile delinquents led to drug use via lowered self-esteem. In addition, distorted self-image and lowered self-esteem were found among some women alcoholics (Kinsey, 1968; Wood and Duffy, 1966). Lowered self-esteem and negative self-images may also have led to involvement in peer groups who shared similar, lowered self-esteem. These peer groups may have been more prone to involvement in alcohol and drug use. Thus, the involvement in the substances may have resulted from peer pressure.

In our earlier work with a sample of alcoholic women, victims of childhood sexual abuse reported feeling different from other girls, in part due to negative sexual self-labeling. These negative labels that may be self or socially reinforced were hypothesized to be important to the development of a self-image that made the development of alcoholism problems more likely (Miller, Gondoli, & Downs, 1987b). Victims of childhood sexual abuse also reported a tendency to associate with deviant peer groups, in part as a result of negative self-labeling (Miller, Gondoli, & Downs, 1987b). Rose and Downs (1988) found that these lower status peer groups were labeled in strong negative terms (e.g., Rejects, Druggies) and were more likely to abuse alcohol and drugs during adolescence. These lower status peer groups also reported lower levels of self-esteem and higher levels of depression, additional precursors to later substance abuse (Rose and Downs, 1988).

MULTIPLE VICTIMIZATION EXPERIENCES AND THE RELATIONSHIP TO ALCOHOL PROBLEMS

To date, little has been done to examine the effects of multiple victimization experiences and the synergistic effects of multiple victimization on the development of alcohol and other drug problems. Bagley and Ramsay (1985) found that women who had been sexually abused were four times more likely to report parental punitiveness as compared to those who had not been abused. Thus, victims of childhood sexual abuse were more likely to face other forms of abuse during childhood, possibly from different and multiple perpetrators. In our previous work, father-to-daughter (but not mother-to-daughter) severe violence was more likely to have occurred for victims of childhood sexual abuse than for women who reported no sexual abuse during childhood. The sexual abuse perpetrator was typically not the parent committing the abuse. Rather, physical abuse by father and sexual abuse by a different adult were correlated with each other.

Father-to-daughter and/or mother-to-daughter physical abuse may have co-existed with the childhood sexual abuse in different ways. For instance, the same parent may have perpetrated both forms of victimization or each parent may have perpetrated a different form of abuse. Based upon our earlier study of childhood sexual abuse (Miller et al., 1987), a third pattern is anticipated: childhood sexual abuse perpetrated by someone other than a parental figure, and child abuse perpetrated by a parent.

SUMMARY

The literature indicates that childhood experiences of parental violence are related to later maladaptive behavior, including alcoholism in adulthood. However, the literature concerning parental violence during childhood and the development of alcoholism in adulthood is scarce. In addition, this research

has had several limitations, including: being limited largely to clinical samples of physically abused children; the lack of a comparison group for the clinical sample; definitional problems concerning parental violence; and the focus strictly on severe physical violence with the effects of less serious violence or verbal abuse having not been examined. Finally, the literature reports that violence differs across gender of parent, thus indicating the need to distinguish mother and father violence.

Previous studies have also suggested the possibility of a link between experiences of childhood sexual abuse and the development of alcoholism in adulthood. In addition, theoretical literature suggests that some of the antecedents to alcohol-related problems in women are similar to some of the consequences of childhood sexual abuse. However, research in this area also suffers from several methodological problems, such as: the lack of an adequate control group; nonsystematic definitions of alcohol-related problems between treatment samples and the general population; subjective definitions of alcohol-related problems across clinics and counselors as opposed to use of objective tests to measure alcohol-related problems; and lack of an empirical investigation of the theoretical links between childhood sexual abuse and the development of alcohol-related problems.

Exploring the connections between childhood sexual abuse and the development of alcohol problems is made more difficult by the diversity of definitions used for studies on childhood sexual abuse. Childhood sexual abuse may be defined as both noncontact (e.g., exhibitionism, solicitations) and contact (e.g., fondling, intercourse) experiences (Peters et al., 1986) however, noncontact sexual abuse experiences may not result in the same long-term consequences as those where there is contact (Sorrenti-Little, Bagley, &

Robertson, 1984).[2] An additional problem in addressing the antecedents and causes of alcoholism in women is that alcoholic women can be in treatment for other problems (e.g., for mental health issues) or unidentified in the community.

RESEARCH QUESTIONS IN CURRENT STUDY

The analyses presented in this paper are based upon data collected from a larger study designed, in part, to examine the links between child abuse, childhood sexual abuse and development of alcohol problems for women. The findings presented in this paper represent the first look at the rates of these types of victimization for alcoholic women and two comparison groups. Our research addresses some of the methodological issues by including two control groups, systematic and objective criteria to define alcoholism, systematic definitions of sexual abuse and parental violence, and an examination of combinations of parental violence and sexual abuse on the victim. Our research bridges some of these gaps in the literature and extends our earlier work, which compared alcoholic women with a random sample, by adding an additional comparison group, women who are not alcoholic but who have received treatment for other types of problems.

Three major questions are being addressed in this paper:

(1) Are alcoholic women more likely to have experienced child abuse than either the general population or women in other types of treatment?

(2) Are alcoholic women more likely to have experienced childhood sexual abuse than either the general population or women in other types of treatment?

(3) Are alcoholic women more likely to have experienced combinations of child abuse and childhood sexual abuse, as compared to either of the other two groups?

METHOD

OVERVIEW

Four samples of women from the larger study are used in these analyses.[3] 1) alcoholics in outpatient alcoholism treatment (n=73), 2) victims receiving services for severe partner violence (n=89), 3) outpatients from mental health treatment (n=48), and 4) a random household population (n=100). To be eligible for the study, women had to qualify for one of the four aforementioned samples and be between the ages of 18 and 45 years.

Each participant had a 2 1/2 hour, face-to-face in-depth interview that included both structured and open-ended questions on child abuse, childhood sexual abuse, and demographics.[4]

SAMPLING

Alcoholic women were currently receiving treatment for alcoholism through one of six clinics in Erie County. They were recruited at the clinics either through personal contact by one of the interviewers or through flyers which were given to eligible women by their counselors. No minimum length of sobriety was set by the study design for alcoholic women; however, individual clinics set times ranging from 6 weeks to 6 months as the minimum length of sobriety before they would allow access to their clients.

The majority of the battered women (77%) were recruited during their stay at a shelter for battered women. During the house meetings, residents of the shelter were informed by research staff of the research project and given an

opportunity to participate. The remainder were receiving counseling services for battered women at an agency affiliated with the shelter. They were either given flyers by their counselors or contacted by an interviewer before the start of their group counseling session.

Women in mental health treatment at four different clinics were recruited through flyers which were given to them by their counselors. Women who were either actively psychotic or suicidally depressed were excluded. In the first instance, actively psychotic women were not expected to be able to provide reliable data for the study. In the second instance, the exclusion was based upon the concern for the women; the interview dealt with extremely sensitive issues and there was concern that the interview process might contribute to negative consequences for the women.

The random sample was recruited through random digit dialing in the Buffalo area. If there was a woman in the household between the ages of 18 and 45 the study was described briefly to her and participation was solicited. Out of a total of 331 contacts with a woman 18-45 living at the residence, 34% refused before hearing the description of the study, another 29% refused after hearing about the study, 7% agreed to be interviewed but failed to establish or keep appointments, and 30% were interviewed.

INTERVIEW PROCEDURE AND OPERATIONALIZATION OF MEASURES

The first wave of interviews were conducted between March 1989 and July 1990.[5] Prior to signing informed consents, participants were told that the interview would include questions about childhood family relationships, childhood sexual experiences, parental alcohol and drug use, current family, relationship with spouse/partner, and her own and her partner's alcohol and

drug use. Respondents also consented to have the interview tape-recorded. All respondents agreed to continue with the taping of the interview.

Experiences of family violence were assessed using the Conflict Tactics Scale or CTS (Straus, 1979; Straus, Gelles, & Steinmetz, 1980). Women were asked to describe conflicts they experienced in their interactions with their mothers and with their fathers.[6] The CTS measures negative verbal interaction, moderate physical violence and severe physical violence. The CTS was modified slightly for the present study. Two items were added to the negative verbal index: "insulted or swore at you in a sexual manner" and "threatened to abandon you." Three other items were deleted ("sulk and/or refuse to talk about it", "stomp out of the room or house" and "cry") because they were not indicators of verbal aggression. Second, because virtually all respondents claimed that their mothers and fathers had slapped or spanked them, this item was deleted from the moderate violence scale. Thus, the modified CTS used in the study consisted of 4 negative verbal items, 4 moderate violence items and 7 severe violence items. Each item on the CTS was dichotomized into 0=never happened and 1=happened at least once. If any item on the CTS subscale was present, there was a positive indication for that subscale.

Previous research has shown that multiple questions of a specific nature produce more reports of sexual abuse than single, more general questions (Peters, Wyatt, & Finkelhor, 1986). Therefore, the interview questions on sexual abuse were generated from the list of questions created by Finkelhor (1979) and supplemented with questions developed by Sgroi (1982). Criteria were established for defining sexual abuse experiences and perpetrators. Sexual abuse was defined by a range of sexual experiences including:

suggestion to do something sexual, sexually oriented touching (e.g., of breast, abdomen, thighs), masturbation ("other person touched your genitals"), digital penetration ("other person put finger or object into your vagina or anus"), and intercourse. The interviewer read a list of specific sexual experiences to which the respondent answered yes or no. Perpetrators were defined as someone who did one of these acts to her prior to the age of 18. Furthermore, perpetrators were defined as someone at least five years older, any relative, or someone who had initiated any of these actions against her will. For each perpetrator mentioned, the respondent was asked the perpetrator's relationship to her, both their ages at the time of the event, approximately how many times the abuse occurred, and over what length of time these events had occurred. Respondents were also asked to identify the most traumatic sexual abuse experiences and to describe the event from their perspective. Questions about childhood sexual abuse were asked approximately 1/2 hour into the interview to ensure that some time had been allowed for establishing rapport with the interviewee. Each respondent was told that she would be asked questions about childhood sexual experiences that she may or may not have experienced.

Sexual experiences were categorized to form three subscales comprised of the following specific sexual experiences: 1) Exposure -- "an invitation or suggestion to do something sexual", "other person showing genitals to you", "you showing genitals to other person"; 2) Touching -- "kissing or hugging in a sexual way", "other person fondling you", "you fondling other person", "other person touching genitals with hands or mouth", "you touching other person's genitals with hands or mouth", and "person rubbing genitals on your

body without penetration"; 3) Penetration -- "intercourse" and "person putting finger or object into your vagina or anus."

Quantity and frequency of alcohol consumption were obtained, modeling questions used by Wilsnack (1986) in the National Health and Leisure Time Survey. Also, following Skinner's approach, we asked respondents for the reasons behind their changes in drinking. In addition, a 30-day Quantity-Frequency of alcohol usage was calculated. For women in treatment, the 30-day interval assessed was that immediately before treatment began; for random sample women, this was the last 30 days. These questions and calculations were drawn from Armor and Polich (1982) and represent the measure of alcohol consumption recommended by a special advisory panel to the National Institute on Alcohol Abuse and Alcoholism.

Other questions assessed race, age, and marital status. Socioeconomic status was calculated using the Hollingshead index for the respondent's family of origin as well as for the respondent either singly or, if she was married or cohabitating, jointly for her and her partner.

CATEGORIZATION OF SAMPLES AND DATA ANALYSES

The purpose of the present paper was to determine whether experiences of childhood family violence and sexual abuse are linked to the development of alcoholism. For this reason, comparisons were made between alcoholic women in treatment and a random sample of the general population, and between alcoholic women in treatment and nonalcoholic women who are in treatment for problems, other than alcoholism.

A screening instrument for alcoholism was needed to ensure that women from the random, battered, or mental health samples were not "hidden" alcoholics. The Michigan Alcoholism Screening Test or MAST (Selzer, 1971) is designed to

be a consistent, quantifiable, structured instrument to detect alcoholism. Although developed for a male population, the MAST assesses women adequately (Selzer, Gomberg, & Nordhoff, 1979). The validity of the MAST has been substantiated by comparisons with record data and other diagnostic tests (Selzer, 1971). However, there has been some concern that the MAST produces a high false positive rate of alcoholism (Brady, Foulks, Childress, & Pertschuk, 1982; Gibbs, 1983; Jacobson, 1983). Although the original cutoff for the MAST was 5 or more, a cut-off of 10 or more was recommended by Jacobson (1983) to address the false positive rate. For women who scored between 5 and 10 on the MAST, patterns of alcohol usage over time were examined as a second criterion measure. Women in this borderline range on the MAST and who had at least one heavy drinking lifetime period (defined as drinking an average of at least 6 drinks per occasion) were defined as alcoholic for the purposes of these analyses. Those who scored in the borderline range but did not have any heavy drinking periods were considered falsely identified as alcoholics by the MAST.

All women who were recruited through the alcoholism clinics met these standards of alcoholism. In addition, 34 women in the battered women sample and 20 women in the mental health sample also met the above criteria for alcoholism. These women subsequently were added to the group of women who received alcoholism treatment and together, the group (n=127) became defined as alcoholic women receiving some type of treatment.

The remaining 55 women in the battered women sample and 28 women in the mental health sample did not have indicators (MAST/alcohol consumption) for alcoholism. These women formed our second group (n=83), defined as nonalcoholics receiving some type of treatment.

To eliminate any alcoholics from the random sample, the same criteria (MAST and alcohol consumption) were employed. A total of 8 women were excluded based upon these criteria for alcoholism from the random sample. The third group (n=92), is based upon the random sample of households, and thus, is considered as reflective of the general population for Western New York.

Rates of child abuse and child sexual abuse were compared for the three groups. Planned contrast t-tests were performed for each independent variable between each pair of samples.[7] Interview transcripts were reviewed for approximately 30 cases for potential theoretical explanations regarding the connections between child abuse/childhood sexual abuse and the development of alcohol and/or drug problems.

RESULTS

Demographics. There were no statistically significant differences in age for the alcoholic women, nonalcoholics in treatment, and general population (x=32, 31, and 33, respectively). There were also no significant differences in race, marital status, adult or childhood socioeconomic statuses for alcoholic women and nonalcoholics in treatment. However, there were significant differences for demographic variables (excluding age) for alcoholic women and the general population. Significantly fewer of the alcoholic women were white (61%) as compared to the general population (77%). Significantly fewer of the alcoholic women were married or cohabiting (27%) as compared to the general population (59%). Alcoholic women had significantly lower socioeconomic statuses in both childhood and adulthood as compared to the general population. Over half of the alcoholic women (52%) had lower socioeconomic status in adulthood as compared to approximately one fourth of the general population (25%). Over half of the alcoholic women (58%) had

lower to lower-middle socioeconomic status in childhood as compared to 40% of the general population.

Child Abuse Experiences. Alcoholic women were significantly more likely to have experienced father-to-daughter severe violence and verbal aggression than either nonalcoholics in treatment or the general population (see Table 1). Two thirds (68%) of the alcoholic women experienced verbal aggression as compared to 44% and 32% of the nonalcoholics in treatment and general population, respectively. Experiences of severe violence by the father occurred for 42% of the alcoholic women, as compared to 23% of the nonalcoholics in treatment and 12% of the general population. Experiences of moderate violence were significantly different only between the alcoholics (52%) and general population (34%).

A greater percentage of all groups experienced verbal aggression and physical violence from their mothers, as compared to their fathers. For example, in the general population sample, half of the women reported verbal aggression and nearly one third (29%) reported severe violence from the mother. In comparison, this same group reported lower levels of father-to-daughter verbal aggression (32%) and severe violence (12%). Likewise, for the nonalcoholics in treatment, more women reported all levels of mother-to-daughter victimization than father-to-daughter victimization. The differences were not as striking for the alcoholic women in treatment. With the exception of moderate violence, the levels of mother and father-to-daughter victimization were approximately the same.

When comparing alcoholic women with the two comparison groups, significant differences in the mother-to-daughter aggression were noted only between the alcoholic and general population. Approximately three-fourths (73%) of the

alcoholic women as compared to approximately half (53%) of the general population experienced negative verbal aggression and moderate violence. Approximately half (47%) of the alcoholic women, as compared to slightly less than a third (29%) of the general population, had experienced severe violence from their mothers.

Since there were significant demographic differences between the alcoholic women and general population, discriminant function analyses were performed to determine whether the verbal aggression and physical violence subscales predicted membership in the alcoholic group, controlling for the demographics. Separate discriminant functions were completed for each independent variable of mother-to-daughter or father-to-daughter verbal aggression, moderate violence, and severe violence. Thus, six different discriminant functions were completed. The fathers' verbal aggression, moderate and severe violence were all significant predictors of group membership, controlling for demographics. Only mothers' verbal aggression remained significantly different in discriminating between alcoholic women and the general population, controlling for demographic differences.

Childhood Sexual Abuse Experiences. Alcoholic women were significantly more likely than either of the comparison groups to have experienced each of the three forms of childhood sexual abuse: exposure/invitation, touching/fondling, and intercourse (see Table 2). Well over half (59%) of the alcoholic women had experienced exposure or invitation to do something sexual, as compared to 47% of the nonalcoholics in treatment and 29% of the general population. Close to two thirds (61%) of the alcoholic women reported sexual abuse experiences of touching/fondling as compared to 41% of the nonalcoholics in treatment and 26% of the general population. When sexual abuse experiences

of intercourse were considered, 43% of the alcoholic women, 31% of the nonalcoholics in treatment, and 12% of the general population had these experiences; the alcoholic women reported statistically greater levels of this type of sexual abuse than the general population, but not greater levels than the nonalcoholics in treatment.

For the overall measure of any type of sexual abuse, alcoholic women were significantly more likely to have experienced childhood sexual abuse as compared to either nonalcoholics in treatment or the general population. Nearly three-fourths (71%) of the alcoholic women, approximately half (53%) of the nonalcoholics in treatment, and 40% of the general population had experienced childhood sexual abuse.

Fathers and stepfathers were unlikely perpetrators for any of the victims of childhood sexual abuse. Only 8% of the women had a sexual abuse incidents involving fathers and 8% with a father figure, which may include stepfather, mother's boyfriend, or foster father. Other perpetrators included relatives (41%) and non-relative perpetrators (66%).[8] There were no significant differences in the percent of fathers/stepfathers involved in the sexual abuse incidents across the three groups.

Multiple Childhood Victimization Experiences. Some women experienced both severe parental violence and childhood sexual abuse while other women experienced one form of victimization and not the other. To determine whether alcoholic women were more likely to have experienced multiple forms of abuse, the two types of experiences were examined together (see Table 3). Alcoholic women were significantly more likely to have experienced a combination of child abuse and childhood sexual abuse as compared to the general population; half of the alcoholic women had both types of victimization experiences as

compared to 19% of the general population. However, nonalcoholics in treatment were not significantly different from the alcoholics in treatment in their experiences of multiple victimization. Alcoholic women were significantly less likely to have escaped any victimization as compared to the nonalcoholics in treatment and to the general population. No victimization was reported by 13% of the alcoholics, 30% of the nonalcoholics in treatment, and 41% of the general population.

DESCRIPTIVE ACCOUNTS OF THE CONNECTIONS: CHILD ABUSE, CHILDHOOD SEXUAL ABUSE, AND ALCOHOL/DRUG USE.

Women's descriptive accounts of the most traumatic child abuse and childhood sexual abuse incidents were examined for information regarding how and why these events may set the stage for the development of alcoholism in women. In addition, women were asked to describe their reasons for drinking, for each changing pattern of drinking during their lifetime. Case histories with multiple victimization (i.e., both severe child abuse and childhood sexual abuse) were examined in order to obtain some preliminary understanding of how and why these events may be connected. Approximately 15 different cases were examined where the child abuse and childhood sexual abuse were experienced by the same perpetrator and approximately 15 cases were examined where the child abuse and childhood sexual abuse were experienced by different perpetrators. Illustrative examples of these data are presented here to provide an initial look at the complexity of dimensions present and the interweaving of violent events in their lives.[9]

Different Perpetrators. Connections between child abuse, childhood sexual abuse, and the development of alcohol problems are convoluted. Although child abuse may have been described as a form of discipline, there was terror

expressed from the recall of these incidents. This terror permeated the child-parent relationship and set the stage for the inability to communicate with parents about the experiences of childhood sexual abuse. In one case history, both the mother and father had been brutal in their methods of disciplining their child. In one incident, the mother beat her for tearing up her new dress. In another incident, the woman yelled at her mother and in response, the mother chased her down the stairs with a broomstick. When the woman fell to the bottom of the stairs, the mother proceeded to break the broomstick over the woman's back. A humiliating and brutal father-to-daughter experience was recalled from a family reunion. When the woman refused to give her cousin some of her money as her father demanded, the woman was hit with a razor strap in front of a large crowd of relatives and strangers.

These experiences of terrorization made women vulnerable to others who victimized them as well. In this same case, the woman was sexually abused by her babysitter's brother, who had sexual intercourse with her on several occasions beginning at age 9. This 17 year old male used her fear of being victimized by her parents as a way of ensuring her silence:

> I don't know why I kept saying yeah and agreeing to it, but I was scared because he kept saying he was going to tell my mother and she was going to whoop me so I would say ok.... not thinking that if he would have told my mother he would have been in trouble too. I wasn't thinking, the only thing I was thinking about was he was going to tell my mother and I was gonna get it.
>
> . . . . Afterwards I was so ashamed, nervous, running into things. When his sister came in I fell over the table and she asked me what was wrong with me and I told her nothing. I was just real nervous and when I saw my mother my heart just went "boom" like somebody was inside my heart, I couldn't breathe because I knew I was in the wrong. I thought she is gonna kill me if she found out, and I never told her to this day she still don't know.

The initial trauma was followed by a change in her behavior which was subsequently noticed by others. However, she was still unable to overcome her fears to speak about her victimization:

> I would get real quiet and (my mother) would ask me why I was so quiet. I got quiet in school. ...I did start smoking when I was 10 because my nerves were so bad. The doctor put me on Valium when I was 14...I used to have headaches, why I don't know. I would go to the doctor and they never could find anything. I used to just sit there crying and holding my head... I got quiet and my nerves were shot.

These feelings were never resolved in her childhood and she continued to have recurring bad feelings about these experience in her adult years:

> ..and it bothers me a lot now. I get headaches and I have dreams about it. Like somebody is inside my head beating me with a hammer or something and I sweat so much I wake up. It is just like I am back to being 9 years old and I will just wake up. (Interviewer: You have nightmares?) Yes, and sometimes they seem so real. I will get up in the middle of the night and it seems like I still see it.

Drinking and drug use was not tied directly to these violent childhood experiences. Rather drinking was seen as a way of dealing with her own internal states and to help her become more social. She indicated that her reason for drinking prior to age 18 was to be less nervous. Her reasons for using a variety of drugs was for her nerves...."I have always been shy. Once I took drugs it was like I was a different person."

In this case the interactions between the child abuse and childhood sexual abuse set the stage for the development of alcoholism problems. The child abuse experiences (by both mother and father) made her afraid to divulge her

experiences of childhood sexual abuse to her parents. The girl believed that this revelation might result in further parental physical abuse. The undisclosed sexual abuse experience led to anxiety, nervousness, and other internal tensions. These internal feelings resulted in a doctor prescribing Valium to her at age 14. This did not resolve the underlying tensions in her life and may have established the belief that socially proscribed drug use was an appropriate mechanism for coping. This may be an especially important connection given that drugs were a socially proscribed coping mechanism by an authority figure.

Same perpetrator. In the following excerpt, the woman's father was both physically violent and sexually abusive. The woman recalled the most upsetting physical violence incident as follows:

> You want the worst one, there was series of them. How about the time when he pushed me out the window and we lived on the fourth floor of the apartment building. I hung on the window sill. My father wanted to make sexual advances with me and I was of an age where I was really starting to fight back. I don't really know if he meant for me to go out the window. ...I got my footing and I kicked him. It was the first time I had ever really done that, I just kicked him. I just lost it and I kicked him. I was like the first time that I said "hah. I got you back."

Later in the interview the woman talked about her most traumatic sexual abuse experience with her father. She again described physical violence mixed with the sexual abuse.

> ...he would sit and talk with me and then the conversation would switch toward the sexual connotations. I would already know it was coming up and I was already at the age where I was really starting to say "No, I don't even want to hear this

anymore." I must have said something to make him mad because I remember him chasing me around the house and I remember him pinning me down and raping me. I remember feeling really helpless, like there is no way out, there is just no way out from this. The way it ended was that the whole time he was doing it, I was cursing at him and telling him what I really felt. Afterwards he came to me and told me how very sorry he was and all this other shit. That was supposed to be forgiven, I suppose. That is sort of how it ended.

Immediate reactions after this experience reveal the traumatic state in which these incidents left the woman. She described a situation she could not believe was happening and from which she felt no recourse was available.

(Interviewer: Immediately after that incident, what was your reaction, what were your feelings and thoughts?) "That I lived in some kind of a crazy house. I remember I used to do this thing, I used to pinch myself because I would think, well, maybe this is a nightmare or maybe I am really dead. So if I feel something that must mean I am alive. I used to think that a lot, because I wasn't really quite sure, like if this was really going on here. I remember feeling really angry and really alone. I always felt very alone, very helpless."

Drinking was described as a way of dealing with life and a way to escape from feelings of being overwhelmed. All aspects of life were described as overwhelming...."Just everything that was going on in the house, the kids, the bills, being single, a relationship not working out." The combined effects of alcohol and drugs were also perceived as desirable. "(Alcohol and drugs) make me very relaxed and very sleepy. It makes me feel numb, like I don't feel too much of anything, like you are out of it."

From this case history, violent physical abuse connected to sexual abuse led to feelings of helplessness, anger, and feelings of being alone. She

expressed the view that she had no way out. When she did try to fight back, her life was threatened, further establishing that she was indeed vulnerable and defenseless. These experiences helped establish that drinking was a way of coping with unbearable life circumstances. Drinking as an escape, when all other methods of escape seemed impossible, was an important undercurrent of the connections between violent victimization and the development of alcohol problems.

DISCUSSION

Alcoholic women in treatment reported extremely high levels of child abuse, childhood sexual abuse, and multiple victimization. Nearly three-fourths of the alcoholic women had some type of sexual abuse experience. Intercourse as a form of childhood sexual abuse was experienced by 43% of the alcoholic women. Severe violence by the father was experienced by 42% of the alcoholic women. Moderate violence (52%) and verbal aggression (68%) were common for alcoholic women. These levels of violent victimization and their accounts of the impact of these events support the importance of these events to their lives and in the development of alcohol problems.

Levels of victimization were statistically higher for the alcoholic women as compared to the general population. As compared to nonalcoholics in treatment, alcoholic women in treatment are more likely to report father-to-daughter verbal aggression and severe violence. Further, they were more likely to report some experience of childhood sexual abuse, especially sexual abuse experiences of fondling/touching. Alcoholic women were significantly less likely to have reported no victimization as compared to either of the two comparison groups. Thus, while the rates of victimization were also high for

nonalcoholics in treatment, these forms of victimization appeared to be especially tied to the development of alcoholism for women.

Although childhood sexual abuse, verbal aggression, and physical violence were important predictors for women's alcoholism, it is important to establish some cautions. First, not all women alcoholics were physically and/or sexually abused. While most (87%) were, 13% were not. Other contributors important to the development of alcoholism must be examined. Second, physical and/or sexual abuse may have been unimportant to the development of alcoholism in some women. Finally, there were women in the comparison groups who had previously experienced child abuse and/or childhood sexual abuse but who had not developed alcoholism, at the time of this interview and may never develop alcoholism. Thus, these experiences do not guarantee the development of alcoholism in women. Finally, it is important for us to understand the complexity of the interrelationship of these victimization experiences to the development of alcoholism in women.

While mothers generally had higher rates of violence in the three groups, father-to-daughter violence may be more important to the development of alcoholism problems. A similar pattern was found in our previous work and several reasons were suggested for the greater importance of father-to-daughter violence (Downs et al., 1987). First, the same violent act may be more severe when perpetrated by the father, due to greater male strength or perceived greater strength. Second, fathers may have greater power within the family structure. Third, there may be more positive interactions between mothers and daughters that may counteract the negative mother-daughter experiences.

Based on the descriptive accounts and the women's interpretations, victimization experiences set the stage for negative feelings about themselves and about their lives, including the lack of control. Two different theoretical explanations seem relevant from our preliminary assessment of these accounts. First, in an indirect manner, feelings of powerlessness and hopelessness set the stage for using alcohol and other drugs as a mechanism to cope with overwhelming problems and situations. Experiences of childhood sexual abuse have been postulated to produce traumagenic dynamics, including feelings of powerlessness (Finkelhor and Browne, 1985). These feelings of powerlessness lead to fear and anxiety as an individual is unable to control what is happening to them (Finkelhor and Browne, 1985). Descriptive accounts presented lend some support to this connection.

A second theoretical explanation that appears important to understanding the dynamics between childhood victimization and the development of alcohol/drug problems in women is that interaction effects between different forms of abuse provide the necessary genesis of coping strategies such as alcohol abuse. The descriptive account of how the experiences of child abuse prevented a more effective coping strategy for experiences of childhood sexual abuse is one piece of evidence for this connection.

Perpetrators of childhood sexual abuse were rarely fathers or father figures, suggesting that alcoholic women have been victimized by multiple adult figures in a variety of ways. One important parental factor that may contribute to the victimization experiences of children by other than parental perpetrators is parental alcoholism. Additional analyses are planned to examine the contributing role of parental alcoholism to the experiences of violent victimization and the development of alcohol problems for women.

FOOTNOTES

1. Numerous studies have examined the relationship between childhood experiences of parental physical violence and the later development of maladaptive behavior. Much of this research is limited to clinical samples of children defined to have experienced physical abuse from parents and thus is referred to here as child abuse. Child abuse has been associated with the development of juvenile delinquency (Bolton & Reich, 1977; Brown, 1982) and adult criminality (Kroll, Stock, & James, 1985; McCord, 1983; Singer, 1986). Physically abused children have been described as aggressive (George & Main, 1979), having low self-esteem and decreased capacity for enjoyment (Martin & Beezely, 1977; Oates, Forrest, & Peacock, 1985), having decreased cognitive ability (Friedrich, Einbender, & Luecke, 1983), and having less competence in peer group interaction (Howes & Espinosa, 1985).

2. Studies may differ in the definition of childhood sexual abuse by using different age limits for the victim and perpetrator. For example, in his study of college students, Finkelhor (1979) defined sexual encounters of children under age 13 with persons at least 5 years older than themselves and encounters of children 13-16 with persons at least 10 years older. Wyatt (1985) examined incidents prior to the age of 18 when the perpetrator was 5 years older than the subject. If there were less than 5 years difference between subject and perpetrator, only situations which the subject did not desire and which involved some degree of coercion were included. In general, studies have included all sexual contacts which were unwanted. Studies have also established an age difference (e.g., 5 years older) between perpetrator and child, which suggests that the child could not have made a voluntary choice (Peters et al., 1986).

3. A fifth sample of convicted drinking drivers was included in the larger study. This sample will be addressed in subsequent analyses.

4. A follow-up interview was planned for 18 months after the first interview.

5. The first wave of data collection for the larger study will extend through September 1990.

6. For purposes of this study, we extended our definition of mother and father to include those adults who lived with the child and were responsible for raising her for a significant period of time during childhood. Thus, "mothers" include grandmothers, aunts and foster mothers and "fathers" include grandfathers, uncles, and mothers' boyfriends.

7. With three samples and 14 variables, this procedure resulted in 42 t-tests per experiment. Assuming a per-contrast alpha level of .05, the probability of at least one type one error per experiment is approximately .88. The per-contrast alpha level thus was reduced according to the formula $EC = (1 - a)^k/k$ where EC is the new per-

contrast alpha level, a is the old per-contrast alpha level, and k is the number of contrasts per experiment (Myers, 1972). This formula resulted in a per-contrast alpha level of .02. Using .02 as the per-contrast alpha level reduces the probability of at least one type one error per experiment from .88 to .57.

8. The percentages do not equal 100 since women could have more than one sexual abuse experience.

9. Some caution is needed in interpreting this data. Given that a total analyses of these data have not been completed, we cannot say how representative these cases are.

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TABLE 1

CHILD ABUSE EXPERIENCES FOR ALCOHOLIC WOMEN VS. COMPARISON GROUPS

	Alcoholics in Treatment	Nonalcoholics in Treatment	General Population
Father-to-daughter Victimization	(N = 127)	(N = 81)	(N = 90)
Verbal Aggression	68%	44%*	32%*
Moderate Violence	52%	44%	34%*
Severe Violence	42%	23%*	12%*
Mother-to-daughter Victimization	(N = 127)	(N = 83)	(N = 92)
Verbal Aggression	73%	67%	53%*
Moderate Violence	72%	64%	55%*
Severe Violence	47%	42%	29%*

* Significantly different from the alcoholic group, $p \leq .02$

TABLE 2

CHILDHOOD SEXUAL ABUSE EXPERIENCES FOR ALCOHOLIC WOMEN VS. COMPARISON GROUPS

	Alcoholics in Treatment (N = 127)	Nonalcoholics in Treatment (N = 83)	General Population (N = 92)
Types of Sexual Abuse			
Exposure/Invitation	59%	47%	29%*
Touching/Fondling	61%	41%*	26%*
Intercourse	43%	31%	12%*
Any Sexual Abuse	71%	53%*	40%*

* Significantly different from the alcoholic group, $p \leq .02$

TABLE 3

CHILDHOOD VICTIMIZATION EXPERIENCES FOR ALCOHOLIC WOMEN VS. COMPARISON GROUPS

Victimization Experiences	Alcoholics in Treatment (N = 127)	Nonalcoholics in Treatment (N = 81)	General Population (N = 90)
No Victimization	13%	30%*	41%*
Parental Severe Violence Only	17%	17%	18%
Childhood Sexual Abuse Only	21%	14%	22%
Both Parental Severe Violence and Childhood Sexual Abuse	50%	40%	19%*

* Significantly different from the alcoholic group, $p \leq .02$